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I am Jack Hoadley, Research Professor at Georgetown University's Health Policy Institute. I have been studying prescription drug issues for the Medicare population for nearly ten years. Thank you for the opportunity to appear at this briefing.

Many of the problems that beneficiaries are encountering with regard to the new Medicare drug benefit are a natural consequence of some of the design decisions that the Congress and the President made to offer the new Medicare Part D benefit through multiple private plans and to allow these plans maximum flexibility in the design of their offerings. The reliance on private drug plans and the resulting large array of differing plan options has added to the confusion and complexity that have plagued the new program during the initial educational campaign and implementation process.

You have heard today about numerous problems in getting beneficiaries enrolled into the program and problems with the transfer of beneficiaries dually eligible for Medicare and Medicaid into Part D plans. You have heard about difficulties that some beneficiaries have faced at the pharmacy counter: getting their initial prescriptions filled at all, being charged at incorrect cost sharing levels, finding out that the drugs they need are not covered on plan formularies, or learning that prior authorization is required before a drug can be dispensed. While some of these problems may be honest growing pains of the startup of a large new program, many of them could have been anticipated better.

Most beneficiaries are facing a choice of at least three dozen stand-alone drug plans. In some states with a high presence of Medicare Advantage, beneficiaries face a choice of over 50 separate plans. The Medicare Prescription Drug Improvement and Modernization Act of 2003 allows plans to vary their benefit design in terms of deductibles, cost sharing, and coverage in the donut hole. It also allows plans to establish formularies (within certain limits) and to use various cost management tools (prior authorization, step therapy, and quantity limits), and it permits plans to limit their pharmacy networks within certain limits. So the challenge for beneficiaries is not just buying the same product from a large set of vendors, but it is picking among a set of different products offered by these vendors.

The Choices Faced by Medicare Beneficiaries

What decisions does a beneficiary face? Beneficiaries first have to decide whether Part D is right for them. They have to examine their current sources of drug coverage – whether they have coverage through a former employer, the VA, a Medigap plan, Medicaid, a state pharmacy assistance program, and so forth. Then, depending on whether that source of coverage is planning to stay in business and whether it is good coverage, they can make a decision about whether to seek a Part D plan. For those dually eligible beneficiaries whose past coverage was from Medicaid, they do not have the option of staying with the coverage that has worked well for them.

Beneficiaries who decide that Part D is right for them then must decide whether to join a Medicare Advantage plan and thus to make a shift in how all their health care services are delivered or to choose a stand-along drug plan. Depending on where they live, there may be a few or many choices of MA plans, each with different coverage and cost-sharing characteristics. Those who prefer to stick with traditional Medicare then face what may be a daunting challenge of picking from among all the stand-alone prescription drug plans.

What do their choices look like? In a typical state, beneficiaries face a dizzying array of options:

- An array of plan sponsors that include national and regional insurance companies, pharmacy benefit managers, with cosponsors that include drug store chains, retailers, AARP, and so forth.
- Premiums that vary by region and range from under $20 to $70 or more
- Plans with a $250 deductible and plans with no deductible
- A few plans with 25 percent cost sharing for all drugs and many plans with tiered copayments
- Copayments for generic drugs that range free to $10 per monthly prescription
- Copayments for brand-name drugs that range from $15 to as high as $66
- Even higher cost sharing when coinsurance is used, in one case set at 75 percent of the cost of the drug for non-preferred brand-name drugs
- Varying pharmacy networks
- Different cost sharing rules for a 90-day supply of a drug
- Different rules for getting an emergency prescription for an out-of-network pharmacy

On top of these differences in the design of benefits are differences in what drugs are covered. Plans have taken advantage of the considerable flexibility allowed by law in establishing formularies and in applying restrictions to some of the drugs that are on their formularies. I have been studying plan formularies with funding from the Kaiser Family Foundation. Although we have not completed that analysis, I can tell you that there are substantial variations among plans and thus beneficiaries will need to examine their options carefully.

- Plans cover between 73 percent and 96 percent of the 200 most commonly prescribed drugs, according to CMS data.
- Coverage of less commonly prescribed drugs tends to be even more varied across plans
- Some plans assign a substantial proportion of their covered brand-name drugs to a non-preferred tier with copayments typically in the $50 to $70 range.
- Some plans make extensive use of coverage restrictions (prior authorization, step therapy, and quantity limits), applying them to many covered drugs, while other plans rarely use these restrictions.
- Plans charge different prices when beneficiaries are in the coverage gap or donut hole.

Beneficiaries can learn about some of these features of competing plans through the Medicare.gov website, providing they or someone helping them is skilled at use of the Internet. But access to that information is difficult. Not only do users need to come prepared with a list of the drugs the beneficiary is taking, but they also need to know the drug's exact form and strength and the dosage pattern. The CMS website offers the option of asking for the most common form and strength of most drugs, but it always uses a default dosage of 30 pills for a monthly supply – regardless of whether the particular drug might be taken twice a day, once a week, or as needed. Thus, the user must be diligent and quite precise to get the correct comparison of coverage and pricing among all the plan options. In addition, the website lists whether the plan applies usage restrictions on the drugs, but does not allow the beneficiary to determine whether prior authorization will be difficult to obtain in a particular situation or what the actual quantity limit on a particular drug will be. This information is probably only available after beneficiaries sign up for a plan and proceed to fill the prescription in question.

Once beneficiaries determines whether their particular drugs are covered, at what cost, and with what restrictions, this information can be combined with information about whether their preferred pharmacy is included in plans' networks and with other information about particular plans (e.g., a preference for no deductible, the reputation of a particular sponsoring organization, etc.).

Having made a decision, the beneficiary can then follow the steps to get enrolled, wait for their application to make its way through the plan's and CMS processes, and get their member number, identification card, and plan-specific information about procedures. Having accomplished all that, the first trip to the pharmacy may bring more surprises as beneficiaries learn about restrictions that may apply to their drugs. And after March 1, plans are permitted to change their formularies with 60 days notice.

Most beneficiaries who are dually eligible for Medicare and Medicaid have been auto-assigned to a plan, a step that may help reduce their decision-making burden. In addition, their cost sharing is restricted by law, so tiered cost sharing is not their concern. But these beneficiaries are more likely to run into restricted formularies in their Part D plans than they did under Medicaid. As a result, many dually eligible beneficiaries may find it advantageous to select a different plan than the one to which they were assigned automatically.

Conclusion

The complexity of the decisions that beneficiaries need to make comes as a direct consequence of the political choices made in 2003 when Medicare Part D was created. The Congress set up Part D to be a competitive marketplace for competing plans. But it is not clear that beneficiaries prefer this type of market for their drug benefit. As one beneficiary said recently, "Why can't this be more like Medicare? Why can't the program just pay 80 percent?"

Furthermore, the decision to give maximum flexibility to plans in their offerings is threatening the success of Part D as a competitive market. If consumers do not have the information base to make informed choices, then the market will not work. The absence of standardization makes it hard for a beneficiary to make an "apples to apples" comparison among the competing plans. In addition, beneficiaries lack critical information they need to make informed decisions, such as how prior authorization will work for their drugs.

Medicare beneficiaries deserve to have a good drug benefit as part of their Medicare coverage. Today, many beneficiaries are struggling to figure out how to take full advantage of the Part D benefit that has been made available to them. Some relatively simple steps, such as more standardization of the available choices or extension of the initial period for education and enrollment, could be taken to ease their struggles. Such steps could begin the process of transforming Part D into a meaningful and workable drug benefit.